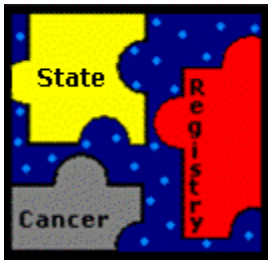
OKLAHOMA
State Department
of Health

Oklahoma Central Cancer Registry

Web Plus User Manual



Updated June 2022

Table of Contents

Oklahoma Central Cancer Registry (OCCR) Staff

Raffaella Espinoza, MPH Analytics & Dissemination Manager raffaellae@health.ok.gov 405-426-8026	Vacant Cancer Surveillance Coordinator 405-426-8010
Christy Dabbs, AA, CTR Data Manager christyd@health.ok.gov 405-426-8012	Vacant Compliance & Education Specialist 405-426-8011
Paula Marshall, BBA, CTR Quality Assurance & Operations Specialist paulam@health.ok.gov 405-426-8014	Judy Hanna, HT (ASCP), CTR Pathology Laboratories Specialist judyh@health.ok.gov 405-426-8013
Leslie Dill Ambulatory Surgery Center/ Dermatology Office Consultant leslied@health.ok.gov 405-426-8017	Lisa Fulkerson, RMA Facility Consultant, Large Hospitals lisaf@health.ok.gov 405-426-8015
Kerri Torgler, BSHIM, RHIT Facility Consultant, Small Hospitals Kerri.Torgler@health.ok.gov 405-426-8018	Vacant Treatment Center/Physician Office Consultant 405-426-8016

Section 1

Core instructions for Reporting Facilities

OKLAHOMA State Department of Health

Electronic Coding Manuals/Databases

International Classification of Diseases for Oncology (ICD-O) Manual, Third Edition

Use**:** To determine applicable codes for primary site (topography), and histology (morphology).
The ICD-O-3 book (purple book) has three main sections: topography, morphology and the alphabetic index. There is also a brief listing of behavior codes and grades. The alphabetic index contains both topography and morphology codes which make it an excellent starting point when looking for key words within a diagnosis or primary site. Codes in the alphabetic index can be looked up in the topography and morphology sections for additional terms which qualify for a specific code.

The World Health Organization (WHO) publishes the ICD-O manuals. There is updated content for ICD-O-3.2 with an updated list of histology codes. The completion of a new manual has been delayed due to the COVID-19 pandemic. However, there are instructions and spreadsheets listing the updates. All updates to ICD-O terms and codes are issued through the North American Association of Central Cancer Registries (NAACCR). Abstractors should refer to the following updates to determine ICD-O codes.

ICD-O-3.1
Use for General Instructions and primary site codes only. Do not use this manual for histology codes since it is out-of-date.
https://apps.who.int/iris/handle/10665/96612

ICD-O-3.2
Effective January 1, 2022
https://www.naaccr.org/icdo3/

2022 ICD-O-3 Update to be used jointly with ICD-O-3.2, Solid Tumor Rules, and Hematopoietic and Lymphoid Neoplasm Database

The 2022 ICO-O-3.2 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 01/01/2022 and forward. The 2022 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2. ***This update includes important information on reportable versus non-reportable high grade dysplasia in gastrointestinal sites.***

Do not use the ICD-O tables to code hematopoietic or lymphoid neoplasms. Refer to the online Hematopoietic Database and Coding Manual for these cases. (Histology codes 9590/3 – 9992/3)

Standards for Oncology Registry Entry (STORE) Manual

https://www.facs.org/media/weqje4pk/store-2022-12102021-final.pdf

Use: To provide current data standards for the collection of cancer registry data. This manual provides instructions and standards for coding all required data items and should be the first manual referenced to determine applicable codes, unless indicated otherwise.

SEER Program Coding & Staging Manual 2022
https://seer.cancer.gov/tools/codingmanuals/index.html

Use: To provide additional data standards for the collection of cancer registry data. This manual provides instructions and standards for coding all required data items and should be used as the secondary manual referenced to determine applicable codes, unless indicated otherwise.

NAACCR Edit Detail Report
https://www.naaccr.org/wp-content/uploads/2022/03/Edit-Detail-Report-v22B.pdf

Use: To help understand and resolve edits. The NAACCR Edit Detail Report is an index of errors abstractors may encounter when running data edits on an abstract. If an error occurs, this file can be helpful in understanding why it occurred and how to resolve it. See Section 2, page 48 for more details on how to clear errors.

Grade Coding Instructions and Tables Manual
https://www.naaccr.org/wp-content/uploads/2021/08/Grade-Manual_v-2.1-2022.pdf?v=1647360617
Published August 2021, Version 2.01 Effective with cases diagnosed 01/01/2018 and forward

Use: used to code grade clinical, grade pathological, grade post therapy (yc) and grade post therapy (yp).

Site-Specific Data Items (SSDI) Manual
https://www.naaccr.org/wp-content/uploads/2021/09/SSDI-Manual_v-2.1-2022.pdf?v=1647360617
Published September 2021, Version 2.1 Effective with cases diagnosed 01/01/2018 and forward

Use: To determine codes for site-specific data items (SSDIs). SSDIs identify additional information needed to generate stage or provide predictive/prognostic factors that have an effect on stage or survival.

Solid Tumor Rules (STR)
https://seer.cancer.gov/tools/solidtumor/STM.pdf
Updated 09/17/2021 and Effective with cases diagnosed 01/01/2018

Use: To determine if a tumor is considered one or multiple primaries based on its site and histology, and to determine histology codes for solid tumors.

The STR manual provides general instructions and site-specific rules. It is highly recommended that the general instructions be entirely reviewed prior to utilizing the site-specific rules. There are two separate sets of rules. The multiple primary rules are used to determine the number of primaries. The histology coding rules are used to determine histology. The rules are hierarchical and must be followed in order. Use the first rule that applies and then stop, do not go any further. *Note:* The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site. Use the Hematopoietic Coding Manual for determining multiple primaries and histology.

Hematopoietic Database
https://seer.cancer.gov/seertools/hemelymph/

Use: used for coding leukemia, lymphoma and myeloid neoplasm histology

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Use: determining multiple primaries and histologies for leukemia, lymphoma and myeloid neoplasm

Steps for Using the Heme DB and Hematopoietic Coding Manual see page 23 in the manual.
SEER*Educate provides training on how to use the Heme Manual and DB. Step-by-step instructions are provided for each case scenario to learn how to use the application and manual to arrive at the answer provided.

SEER Rx-Interactive Antineoplastic Drugs Database
https://seer.cancer.gov/seertools/seerrx/

Use**:** database of systemic therapy drugs, i.e., chemotherapy, hormone therapy, immunotherapy and chemotherapy regimens.

Other Resources

SEER Training Modules
http://training.seer.cancer.gov/ and http://seer.cancer.gov/tools/heme/training/

NAACCR Data Dictionary
http://datadictionary.naaccr.org/default.aspx?c=10&Version=22

Use: Provides a general description, specific codes and definitions for cancer registry data items.

Oklahoma Cancer Registrars Association (OCRA) Helpful Links
http://ocra-ok.org/links.asp

SEER Glossary for Registrars
https://seer.cancer.gov/seertools/glossary/

Use: The glossary features definitions for terms used by cancer registrars. Each entry includes information on where the term is used, as well as any applicable alternate names, abstractor notes, histology, and primary sites.

Submission Schedule

Date of 1st contact for Diagnosis, Treatment or Recurrence/Persistence of cancer:	Required to be Submitted to OCCR in:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Reportable Conditions List

REPORTABLE CONDITIONS as of 01/01/2022

Malignancies with an ICD-O-3 behavior code of 2 (in-situ) or 3 (malignant) are reportable for all sites with the following **exceptions**:

	Condition	Reportable/Not reportable
Melanoma	Early or evolving melanoma in situ, or any other early or evolving melanoma effective with cases diagnosed 01/01/2021 and forward.	Reportable
Gastrointestinal Stromal Tumor	All GIST tumors are reportable effective with cases diagnosed 01/01/2021 and forward. The behavior code is /3 in ICD-O-3.2.	Reportable
Thymoma	Nearly all thymomas are reportable effective with cases diagnosed 01/01/2021 and forward. The behavior code is /3 in ICD-O-3.2. ***Exceptions:*** microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).	Reportable with exceptions
Teratoma	Mature teratoma of the testis in adults is malignant (assign 9080/3) but continues to be non-reportable in prepubescent children (9080/0). Report only if pubescence is explicitly stated in the medical record. ***Do not report if there is no mention of pubescence in the medical record.***	Reportable with exceptions
Astrocytoma	Juvenile astrocytoma, pilocytic astrocytoma, or piloid astrocytoma listed as 9421/1 in ICD-O-3. (Assign code 9421/3).	Reportable
Carcinoid Tumor of Appendix	Code 8240/1 for carcinoid tumor, NOS of appendix is obsolete. Carcinoid tumors of the appendix (C18.1) **must be coded to 8240/3** effective with cases diagnosed 1/1/2015 and forward.	Reportable
Appendiceal Mucinous Neoplasm	Low-grade appendiceal mucinous neoplasm (LAMN) behavior changed to 2 effective 2022. High-grade appendiceal mucinous neoplasm (HAMN) behavior changed to 3 effective 2022 effective with cases diagnosed 1/1/2022 and forward.	Reportable
Intraepithelial Neoplasia	Vulvar intraepithelial neoplasia (VIN III), vaginal intraepithelial neoplasia (VAIN III), anal intraepithelial neoplasia (AIN III) with a behavior code of 2 in ICD-O-3	Reportable
Breast Neoplasia	Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast C500-C509 effective with cases diagnosed 2016+.	
Non-Reportable Skin	Malignant primary skin cancers (C44._) with histology codes 8000-8110. (Examples: squamous cell carcinoma (8070) and basal cell carcinoma (8090) of skin are not reportable).	Not Reportable
Non-Reportable In Situ & Intraepithelial neoplasia	Carcinoma in situ (CIS) of the cervix, squamous intraepithelial neoplasia (SIN III), cervical intraepithelial neoplasia grade III (CIN III), and prostatic intraepithelial neoplasia (PIN III).	Not Reportable

Non-Malignant Primary Intracranial and Central Nervous System Tumors
diagnosed on or after 1/1/04 with an ICD-O-3 behavior code of 0 or 1 are reportable for the following sites
Meninges (C70._)
Brain (C71._)
Spinal cord, cranial nerves, and other parts of the central nervous system (C72._)
Pituitary gland (C75.1)
Craniopharyngeal duct (C75.2)
Pineal gland (C75.3)

Case-finding

Case-finding is the means by which a facility identifies patients with a reportable tumor. The following case-finding list(s) should be used by your facility to identify these patients. It is suggested that you use the reportable list as a filter and generate a report listing all discharged patients with a diagnosis of a reportable tumor. The report should be sorted alphabetically to group patients with multiple encounters. All patients on the report will be reviewed to determine their eligibility for reporting. Patients admitted to your facility for an eligible tumor diagnosis, or for tumor-directed treatment must be reported and a tumor abstract completed. No tumor abstract is necessary if it is determined that a patient was admitted with only a history of a malignancy or with a history of benign intracranial/central nervous system tumor (i.e., no procedure done, no treatment tumor-directed).

The patient discharge report should include the following:

- Patient last name
- Patient first name
- Patient middle name
- Medical record number
- Date of birth
- Social security number
- Date of service
- ICD-10 codes
- Type of encounter

An electronic version of the case-finding list is available on the SEER website.
https://seer.cancer.gov/tools/casefinding/

Comprehensive ICD-10-CM Case-finding Code List for Reportable Tumors

Effective October 1, 2020 – September 30, 2021

ICD-10-CM Code	Explanation of ICD-10-CM code
C00._- C43.-, C4A.-, C45._- C48._, C49._-C96._	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site), and certain specified histologies *NEW for FY2018: C96.20 Malignant mast cell neoplasm, unspecified, C96.21 Aggressive systemic mastocytosis, C96.22 Mast cell sarcoma, C96.29 Other malignant cell neoplasm*
C00.- - C43.-, C4A.-, C45.- - C48.-, C49.- - C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies **Note:** The following neoplasm codes are **new for FY2022** (10/1/2021) C56.3: Malignant neoplasm of bilateral ovaries C79.63: Secondary malignant neoplasm of bilateral ovaries C84.7A: Anaplastic large cell lymphoma, ALK-negative, breast
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors Note: All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.- - D09.-	In-situ neoplasms Note 1: Excludes carcinoma in situ of the cervix (D06._) Note 2: Excludes prostatic intraepithelial neoplasia (PIN III-8148/2) of the prostate. Other prostate in situ histologies are reportable. Note 3: For D04 (carcinoma in situ of the skin), excludes basal and squamous cell in situ lesions.
D13.7	Benign neoplasm of endocrine pancreas Note: Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Islet cell adenoma • Nesidioblastoma • Islet cell adenomatosis • Insulinoma

	• Beta cell adenoma
D18.02	Hemangioma of intracranial structures and any site
D21.4, D48.1	Benign neoplasm of connective and other soft tissue of abdomen Note: Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Gastrointestinal stromal tumor, NOS/GIST, NOS/Gastrointestinal autonomic nerve tumor/GANT/Gastrointestinal pacemaker cell tumor (8936/1, now 8936/3)
D23.9	Other benign neoplasm of skin Benign carcinoid tumors of other sites Note: Effective 1/1/2021: Review these code to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Aggressive digital papillary adenoma (c44_) (8408/1, but now 8408/3)
D3A._	Benign carcinoid tumors of other sites Note: Effective 1/1/2021: Review these codes to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Carcinoid tumor, argentaffinoma, NOS (8240/1, now 8241/3) • Enterochromaffin-like cell carcinoid, NOS (8242/1, now 8241/3)
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.00 – D35.02	Benign neoplasm of adrenal gland Note: Effective 1/1/2021: Review this code to look for the following which was previously a benign (8700/0) tumor of the adrenal gland, but is now malignant per ICD-O-3.2 (8700/3) • Pheochromocytoma • Adrenal medullary paraganglioma • Chromaffin paraganglioma • Chromaffin tumor • Chromaffinoma
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D37.8	Neoplasm of uncertain behavior of other specified digestive organs (includes uncertain behavior of pancreas) Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Pancreatic endocrine tumor, NOS (C259, 8150/1, now 8150/3) • Islet cell tumor, NOS (C259, 8150/1, now 8150/3) • Glucagonoma, NOS (C259, 8152/1, now 8152/3) • Alpha cell tumor, NOS (C259, 8152/1, now 8152/3) • Glucagon-like peptid-producing tumor (C259, 8152/1, now 8152/3) • Somastostatinoma, NOS (8156/1, now 8156/3) • Somatostatin cell tumor, NOS (8156/1, now 8156/3) • Endocrine tumor, functioning, NOS (8158/1, now 8158/3) • ACTH-producing tumor (8158/1, now 8158/3)
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D44.6	Neoplasm of uncertain behavior of carotid body Note: Effective 1/1/2021: Review this code to look for the following histologies

	which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Carotid body tumor/Carotid body paraganglioma (8692/1, now 8692/3)
D44.7	Neoplasm of uncertain behavior of aortic body and other paraganglia Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Paraganglioma, NOS (8680/1, now 8680/3) • Sympathetic paraganglioma (8681/1, now 8681/3) • Parasympathetic paraganglioma (8682/1, now 8682/3) • Glomulus jugulare tumor, NOS/jugular paraganglioma/juglotympanic paraganglioma (8690/1, now 8690/3) • Aortic body tumor/aortic body paraganglioma/aorticopulmonary paraganglioma (8691/1, now 8691/3) • Extra-adrenal paraganglioma, NOS/nonchromaffin paraganglioma, NOS/chemodectoma (8693/1, now 8693/3)
D45	Polycythemia vera (9950/3) ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) **Note**: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)
D48.0	Neoplasm of uncertain behavior of bone and articular cartilage Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Clear cell odontogenic tumor (9341/1, now 9341/3)
D49.2	Neoplasm of unspecified behavior of digestive organs (includes unspecified behavior of pancreas)Note: Review this code to look for the following which were previously unknown behavior tumors of the pancreas, but are now malignant tumors per ICD-O-3.2 (Histology 8150/3) • Pancreatic endocrine tumor, NOS • Islet cell tumor, NOS
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.110	Idiopathic hypereosinophilic syndrome [HES] (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia

D72.111	Lymphocytic Variant Hypereosonophilic Syndrome [LHES] (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia Syndrome [LHES]
D72.118	Other Hypereosonophilic syndrome (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
D72.119	Hypereosonophilic syndrome (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

Ambiguous Terminology for Determining Reportability

As part of the case-finding activities, all diagnostic reports (radiology, pathology, autopsy, history and physical, discharge summary) should be reviewed to confirm whether a case is required to be reported. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be reported.

The following lists of terms should be used ONLY to determine if a cancer case is reportable.

Ambiguous Terms that Constitute a Reportable Diagnosis	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical of
Malignant appearing	
Additional Terms that Constitute a Reportable Diagnosis for **Nonmalignant Primary Intracranial and Central Nervous System Tumors Only***	
Neoplasm	Tumor
*Beginning with diagnosis year 2004 and only for C70.0-C72.9 and C75.1-C75.3	

Note 1: Do not substitute synonyms such as 'supposed' for 'presumed', or 'equal' for 'comparable'. Do not substitute 'likely' for 'most likely'. Use only the exact words on the list or their conjugate forms, for example, "favored" is allowed as a substitute for "favor." Do not use terms that constitute a diagnosis in conjunction with the term "mass" as this is not defined as cancer. The term "neoplasm" can only be used in the context above. Otherwise neoplasm can be benign or malignant and is not defined as cancer.

Note 2: If a **cytology report** uses only an ambiguous term for the diagnosis, do not interpret it as a diagnosis of cancer. Do not report ambiguous cytology *unless* a physician makes a statement of malignancy or if the patient receives cancer-directed therapy. If a tissue diagnosis confirms ambiguous cytology, use the cytology date as the date of diagnosis.

Note 3: The ambiguous terms list is applicable to hematopoietic and lymphoid neoplasms for determining **reportability only**. The use of ambiguous terms for assigning and reporting histology is covered in the Hematopoietic and Lymphoid Neoplasms Coding Manual.

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Ambiguous Terms that **DO NOT** Constitute a Reportable Diagnosis	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Ambiguous Diagnostic Terms

Do report - The inpatient discharge summary documents a chest x-ray consistent with carcinoma of the right upper lobe. The patient refused work-up and treatment. *Consistent with carcinoma* is reportable terminology and this case will be abstracted.

Do report – Mammogram report states breast mass is **suspicious** for malignancy. Suspicious for malignancy is reportable ambiguous terminology. Please note, BI-RADS terms are not considered diagnostic on their own. For example, BI-RADS 4, suspicious abnormality, does not constitute a diagnosis.

Do not report – An outpatient CT scan of the chest documents a right lower lobe lung nodule, **possible** malignancy. The patient has no other encounters with your facility. Possible is not a reportable ambiguous term.

Differential Diagnosis

A **differential** diagnosis is made when a physician does not have enough information to assign a **definitive** diagnosis. Only report cases with a differential diagnosis if all possible disease processes are reportable.

Do report – CT exam of the chest shows a nodule in the left lower lung. The radiologist report has a differential diagnosis of **suspicious** for lung cancer vs **metastatic** lung lesion. Both are reportable terms.

Do report – Pathology report of brain tissue states **CNS lymphoma** vs **CNS metastasis** from unknown primary. Both are reportable conditions.

Do not report – MRI of the left thigh says deep tissue mass consistent with **atypical lipoma** or **liposarcoma**. The patient does not return to your facility. Atypical lipoma is not a reportable condition.

Do not report – Bone survey states patient has a solitary lesion in the right humerus compatible with a **bone island** or **solitary plasmacytoma**. “Compatible” is a reportable ambiguous term, but a bone island is not a reportable condition.

Class of Case

Class of case reflects the facility’s relationship to the patient and its role in the diagnosis and/or treatment of the cancer. Code the Class that most precisely describes the patient’s relationship to your facility/physician office.

Classes of Case 00 - 14 indicate that the patient was diagnosed at your facility or in the office of a physician with admitting privileges at your facility.
Classes of Case 20 - 22 indicate that the patient was diagnosed somewhere else (not at your facility and not in the office of a physician with admitting privileges at your facility).

Class of Case

Analytic Cases		R=Required N=Not Required
Initial diagnosis at the reporting facility or in a staff physician's office		**R**
00	Initial diagnosis at the reporting facility/physician office AND all treatment or a decision not to treat was done elsewhere *Note: 00 only applies when it is known that the patient went elsewhere for treatment. If you do not know that this information, you should code Class of Case 10.*	**R**
10	Initial diagnosis at the reporting facility/physician office or, for hospitals, in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS.	**R**
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility. *Note: used by hospitals only. Physician offices, ambulatory surgery centers and treatment centers use class of case 13.*	**R**
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility. *Note: used by hospitals only. Physician offices, ambulatory surgery centers and treatment centers use class of case 14.*	**R**
13	Initial diagnosis at the reporting facility/physician office AND part of first course treatment was done at the reporting facility/physician office; part of first course treatment was done elsewhere	**R**
14	Initial diagnosis at the reporting facility/physician office AND all first course treatment or a decision not to treat was done at the reporting facility/physician office	**R**
Initial diagnosis elsewhere		**R**
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility/physician office, NOS	**R**
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility/physician office; part of first course treatment was done elsewhere.	**R**
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility/physician office	**R**
Non–analytic Cases		
Patient appears in person at reporting facility		
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility performed a confirmation biopsy after being diagnosed on imaging elsewhere. ***Note**: only reportable for confirmation biopsy of initial diagnosis. You must know the patient was clinically diagnosed elsewhere on imaging or physician statement and document that in text. ***DO NOT** report consult only, treatment plan only, staging workup only after initial diagnosis elsewhere)*	**R***
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)	**N**
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility/physician office for diagnosis or treatment of disease recurrence or persistence (active disease). *Note: 32 includes patients that expire at the reporting facility with a reportable active disease that does not meet the criteria for an analytic Class of Case.*	**R**
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility/physician office with disease history only (disease not active)	**N**
34*	***Reportable only for the following histology and primary sites: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*)***	**R***

	Initial diagnosis AND part or all of first course treatment by reporting facility/physician office *for the above diagnoses only.*	
35	Case diagnosed before facility's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility	**N**
36*	***Reportable only for the following histology and primary sties: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*)*** Initial diagnosis elsewhere AND all or part of first course treatment by reporting facility/physician office.	**R***
37	Case diagnosed before facility's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility	**N**
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death ***(for use by hospitals only)*** ***Note: 38 should only be used if the reporting facility performs autopsies***	**R**
Patient does not appear in person at reporting facility		
40	Diagnosis AND all first course treatment given at the same staff physician's office ***(for use by hospitals only)***	**N**
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges. ***(for use by hospitals only)***	**N**
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility) ***(for use by hospitals only)***	**N**
43	Pathology or other lab specimens only ***(for use by hospitals only)***	**N**
49	Death certificate only (central registry only)	**N**
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases). **DO NOT USE**	**N**

Additional explanation:

Class of Case 00 can be used only if the patient was diagnosed at your facility, and you know the patient received treatment elsewhere. If, after diagnosis at your facility, it is unknown if the patient received any treatment, you must code *Class of Case* as 10.

"No therapy" is considered a treatment (i.e., patient refuses treatment, patient expires before treatment is given, or physician recommends no treatment). If a decision of no treatment is made at your facility, class of case should reflect "treatment was administered at your facility".

Examples of class of case:

1. Patient admitted to your facility with rectal bleeding. Colonoscopy performed after admission shows the patient has colon cancer. Two days later, the patient has a hemicolectomy to remove the cancer. The surgeon states the cancer is Stage I and no further treatment is necessary.
    - This is a *class of case* 14 – initial diagnosis at the reporting facility and all first course of treatment was administered at the reporting facility.

2. 90-year old patient with multiple comorbidities admitted to reporting facility with shortness of breath. Lung biopsy is positive for small cell carcinoma. Patient opts to receive no treatment.
    - This is a *class of case* 14 – initial diagnosis and all first course treatment administered at the reporting facility. ("No treatment" is treatment).

3. Patient presents to ER having a cardiovascular event and a history of colon cancer. During the hospitalization it is determined that patient has a newly diagnosed liver lesion confirmed to be metastasis from colon cancer on pathology examination. The reporting facility does not treat this metastasis.
    - This is a *class of case* 32- diagnosis of recurrence or progression of disease. All first course treatment administered elsewhere AND patient presents to the reporting facility with disease

recurrence or persistence (active disease). This case is reportable since progression of disease was diagnosed at the reporting facility.

4. Patient presents to the reporting physician office for a mole that has been present for years. It has recently changed in shape and color. The reporting physician performs a shave biopsy. The pathology results return malignant melanoma with positive peripheral and deep margins. Your physician refers the patient to a surgeon who performs a wide local excision and sentinel lymph node biopsy at an ambulatory surgery center.
    - This is a *class of case* 13 diagnosed at the reporting physician's office, part of the first course treatment was done at the reporting physician's office and part of the first course treatment was done at an ambulatory surgery center.
      A shave biopsy with only microscopic positive margins (not gross positive margins) is considered an excisional biopsy which is surgery code 27 (first course treatment).

5. Patient presents to the reporting hospital for right upper quadrant pain. A CT of the abdomen and pelvis is performed. The impression on the report states a 3.2 cm mass in the liver is highly suspicious for hepatocellular carcinoma. The patient is transferred to another hospital for a higher level of care. It is unknown if the patient received treatment.
    - This is *class of case* 10 – diagnosed at your hospital and unknown if the patient received treatment elsewhere. The patient was diagnosed at the reporting facility on CT with ambiguous terms that constitute a diagnosis. There is no mention in the medical record of any cancer treatment the patient received at the outside facility.

Laterality

Laterality must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded as "right" or "left" laterality, are coded 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of trunk can have a midline tumor, but the breasts cannot.

Code	Label
0	Organ is not a paired site
1	Origin of primary is right
2	Origin of primary is left
3	Only one side involved, right or left origin not specified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

List of Paired Organ Sites

ICD-O-3 Code	Paired Organ Sites
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland

C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bone of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.4	Skin of Scalp and Neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe

C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-74.9	Adrenal gland
C75.4	Carotid body

Diagnostic Confirmation for Solid Tumors

Diagnostic confirmation is an indicator of the precision of diagnosis. The codes for diagnostic confirmation are in priority order; code 1 has the highest priority.

Codes 1, 2, and 4 indicate that the diagnosis of cancer was microscopically confirmed. The cancer diagnosis will be confirmed in a pathology report.

Codes 5, 6, 7 and 8 indicate that the diagnosis was clinically confirmed. There will be no pathology report associated with this diagnosis of cancer. The confirmation will be a physician statement using either definitive terminology or ambiguous terminology. The physician statement may be in a discharge summary, progress note, radiology report, history and physical examination, or other physician note. Code 5 will rarely be used as a means of diagnostic confirmation since laboratory tests/tumor markers are not usually diagnostic of cancer.

Codes for Solid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.

8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Examples of diagnostic confirmation

1. Patient admits to the reporting facility with shortness of breath and productive cough. CT scan of the chest demonstrates a right upper lobe lung mass with enlarged mediastinal lymph nodes. The patient refuses any additional work-up. On the discharge summary, the attending physician states the final diagnosis is lung cancer.
    - The diagnostic confirmation code assigned is 8 – clinical diagnosis only. The physician gave a definitive diagnosis in the discharge summary.

2. Patient referred to the reporting facility for a breast biopsy. The biopsy is performed and the pathologic diagnosis is infiltrating duct carcinoma of the right breast.
    - The diagnostic confirmation code assigned is 1 – positive histology. There is a pathology report with a histologic diagnosis of cancer.

Estimating Dates

If an exact date is not available, use all the information available to calculate the month and year to estimate a date. **Blank dates should be a last resort and are strongly discouraged**.

Documentation	Date code/description
Spring	April (04)
Summer or Middle of the Year	July (07)
Fall or Autumn	October (10)
Winter	Determine if this means the beginning or end of the year. Use December (12) or January (01) as determined.
Early in the Year	January (01)
Late in the Year	December (12)
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code two years earlier
A Few Years	Code three years earlier

Example 1:
A patient was admitted to your facility on June 15, 2018. The History and Physical states the patient has lung carcinoma diagnosed about two months ago. Record the date of diagnosis as 201804__.

Example 2:
A patient was admitted to your facility on October 30, 2019. The History and Physical states the patient has bone metastasis from prostate cancer diagnosed in the spring. Record the date of diagnosis as 201904__.

Section 2

Web Plus Training Narrative

OKLAHOMA State Department of Health

Enter New Abstract

NOTE: there are four abstract displays in Web Plus. Reporting facilities are assigned a specific display based on facility type, number of cases reported, and whether or not the facility provides cancer directed treatment. All data items are covered in this manual. However, not all data items will be in every display.

The Asterisk indicates a required field that must be completed.

Abstracting Notes

Note 1: All dates are entered using the following format: YYYYMMDD. If the day is unknown, leave blank (YYYYMM_ _). If the month and day are both unknown, leave both blank (YYYY_ _ _ _). If the entire date is unknown, leave field blank. Do your best to estimate a diagnosis date using the estimating a date instructions. Very rarely should you have a blank date of diagnosis.

Note 2: Some fields have a drop down arrow.  Use this arrow to display a list of available choices to use for coding.

Note 3: Some fields have a search icon.  Click the search icon to display a search bar/list of available choices for coding.

Note 4: All fields with an asterisk (*) are required fields and must be completed by the reporter, unless otherwise specified.

Note 5: To navigate within the abstract, use the “Enter” key, the “Tab” key or the mouse.

Hospital Specific

Reporting Facility:

Unique number assigned for your facility by OCCR. Data item is auto-coded.

Abstracted By:

Initials of person logged into Web Plus. Data item is auto-coded.

***Date of 1st Contact:**

Date of first patient contact, inpatient or outpatient, for the diagnosis and/or treatment of the tumor. The date may represent an outpatient visit for biopsy, imaging exam or laboratory test. If the patient is diagnosed at the reporting facility, the date of diagnosis and the date of first contact will be the same. If the patient is diagnosed at an outside facility, the date of first contact is the date the treatment starts at the reporting facility. (Treatment is surgery or palliative therapy). (Refer to Note 1 Page 14 for date format).

Date 1st Contact Flag:

Flag explains why no appropriate value is in the field *Date of 1st Contact*. Data item will be left blank if the *Date of 1st Contact* is known. Use drop down and select "12" if Date of 1st Contact is not known. *Note:* You will always have a date of first contact for reportable cases.

Type of Reporting Source:

Codes the source used to abstract the majority of information on the tumor being reported. Use the drop down and select the appropriate reporting source.

***Accession No:**

Provides a unique identifier (9-digit number) for the patient and consists of the year in which the patient was first seen at the reporting facility, as well as the consecutive order in which the patient was abstracted. A patient will have only one accession number in their lifetime. A log of accession numbers must be maintained to avoid duplication. (An example of an accession log will be provided by the OCCR consultant.)

> ***Example:*** First patient abstracted for year 2020 will have accession number 202000001. Second patient abstracted for year 2020 will have accession number 202000002. If first patient returns to facility in year 2021, their accession number will remain 202000001.

***Sequence No:**

Indicates the sequence of all malignant and non-malignant reportable neoplasms over the lifetime of the patient. Sequence number **00** indicates that a patient has only one malignant neoplasm in a lifetime. If this same patient is diagnosed with a second malignant neoplasm, the sequence number for the first neoplasm is changed to **01**, while the sequence number for the second neoplasm is coded **02**.

Sequence number **60** indicates that a patient has only one non-malignant reportable neoplasm in a lifetime. If this same patient is diagnosed with a second non-malignant reportable neoplasm, the sequence number for the first neoplasm is changed to **61**, while the sequence number for the second neoplasm is coded **62**. Do not mix malignant and non-malignant sequence numbers.

***Class of Case:**

Use the drop down and select the class of case that reflects the facility's role in the management of the cancer. A decision to not treat is still considered *treatment*. (See Section 1, pages 8-9 for additional coding instructions).

Patient Information

***Name - Last:**

Record the last name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. Do not leave blank. If the last name is unknown, record as UNKNOWN.

Examples: *Record with space "Mc Donald"; record with a hyphen "Smith-Jones"*

***Name - First:**

Record the first name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. If the first name is unknown, leave blank.

Name - Middle:

Record the middle name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. If only a middle initial is known, record the letter only. If the middle name is unknown, leave blank.

Name - Alias:

Record here if the patient is called by a name other than their first name. If alias is unknown or not applicable, leave blank.

Example: *Patient name is Robert but goes by Bob. Record Bob in this field.*

Name – Birth Surname:

Record patient's last name (surname) at birth, regardless of gender or marital status. If birth surname is unknown or not applicable, leave blank. Beginning 01/01/2021 Name –Birth Surname replaces Name – Maiden.

Name - Suffix:

Record the title that follows a patient's last name, such as generation order or credential status. (e.g., "Jr" or "MD"). If name suffix is unknown or not applicable, leave blank.

***Social Security No:**

Record the patient's social security number without dashes. If social security number is unknown or the patient does not have one, code as 999999999. If a partial social security only is known (i.e., last 4 digits), code as 88888XXXX where "X" represents the known digits.

Medical Rec No:

Record the medical record number, usually assigned by the reporting facility's health information management (HIM) department. If medical record is unknown, leave blank.

Medicare Beneficiary ID:

In April 2018 CMS began transitioning the use of the social security number for a Medicare recipient's identification card to a randomly generated Medicare Beneficiary Identifier. The identifier consists of 11 characters using numbers 1-9 and letters A to Z. Record the Medicare Beneficiary ID number if the patient is a Medicare recipient and you have access to the Medicare Beneficiary ID.

***Date of Birth:**

Record the patient's date of birth. Leave the year, month and/or day blank when they cannot be estimated or are unknown. If the date of birth is unknown, but the age at diagnosis and date of diagnosis are known, calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis. Leave the month and day blank. (Refer to Note 1 Page 14 for note 1).

Date Birth Flag:

Flag explains why no appropriate value is in the field *Date of Birth*. Data item will be left blank if the *Date of Birth* is known. Use the drop down and select "12" if the date is not known.

***Birthplace State:**

Use the drop down and select the state in which the patient was born. If unknown, select "ZZ" for unknown.

***Birthplace Country:**

Use the search icon and select or search for the country in which the patient was born. If unknown, select "ZZU" for unknown.

***Sex:**

Use the drop down and choose the appropriate code to record the sex of the patient.

***Race 1-5:**

Use the drop down and choose the appropriate code to record the patient's race. Race codes 1-5 must ALL be completed, even if race is unknown. If the patient is multiracial, record the minority race in Race 1 and other race in Race 2. Code 88 = no additional races; code 99 = unknown.

Examples:

Patient is Caucasian only:	Patient is Black and Caucasian:	Patient race is Unknown:
Race 1: 01	Race 1: 02	Race 1: 99
Race 2: 88	Race 2: 01	Race 2: 99
Race 3: 88	Race 3: 88	Race 3: 99

Race 4: 88	Race 4: 88	Race 4: 99
Race 5: 88	Race 5: 88	Race 5: 99

***Hispanic Ethnicity:**

Use the drop down and record the patient's Hispanic ethnicity. If ethnicity is unknown, select "9" for unknown. Do not leave blank.

***Primary Payer at DX:**

Use the drop down and select the code that describes the primary payer or insurance carrier at the time of the initial diagnosis and/or treatment. If primary payer is unknown, select "99" for unknown. Do not leave blank.

***Tobacco Use Smoking Status**

Use the drop down and select the code that describes the code that best describes the patients' smoking status. *Do not record the patient's past or current use of e-cigarette vaping devices.*

- Code 1: includes cigarette, cigar, and/or pipe.
- Code 2: If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1, current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.
- Code 9: assign when the medical record only indicates "No"

Patient Address Information

***Number and Street at Diagnosis:**

Record the physical address of the patient at the time of diagnosis. Only record a post office box if you cannot locate in the medical record the physical address where the patient resided at diagnosis.

Supplemental Address at Diagnosis:

Record additional information listed for the patient's address at diagnosis, including nursing home, post office box, etc. If supplemental address is unknown or not applicable, leave blank.

***City at Diagnosis**:
Record the city of patient's physical address at the time of diagnosis.

***State at Diagnosis:**

Use the drop down and select the patient's state of residence at the time of diagnosis.

***Zip Code at Diagnosis:**

Record the extended 9-digit code or the short 5-digit code for the patient's address at the time of diagnosis.

***County at Diagnosis:**

Use the search icon and select or search for the county of the patient's residence at the time of diagnosis. Getzips.com is a quick resource which checks the county within a zip code area. https://www.getzips.com/zip.htm

TEXT - Usual Occupation:

Required when available Record the longest held occupation of the patient if known. If not known enter UNKNOWN, if retired enter UNKNOWN. Example: Teacher

TEXT - Usual Industry:

Required when Available Record the industry of the longest held occupation. If not known enter UNKNOWN, if retired enter UNKNOWN. Example: Education

Cancer Information

***Date of Diagnosis:**

Record the date the cancer was first diagnosed, whether clinically (physician's documentation, x-ray, CT scan) or pathologically (biopsy, surgery). Refer to the list of "ambiguous terms" in Section 1, page 6 for language that represents a diagnosis of cancer. (Refer to Note 1 Page 12 for date format).

Date Diagnosis Flag:

Flag explains why no appropriate value is in the field *Date of Diagnosis*. Data item will be left blank if *Date of Diagnosis* is known. Use the drop down and select "12" if the date is not known.

***Age at Diagnosis:**

Click the calculate button  to compute/derive the age of the patient at diagnosis. Data items *Date of Diagnosis* and *Date of Birth* must be completed to derive the age at diagnosis.

***Primary Site - Text:**

Document the primary tumor site, including sub-site and laterality. Do not leave blank. Primary Site – Text is the written description for the code entered in Primary Site.

Example 1: *Right lower lobe of lung.* (Laterality: Right; Sub-site: lower lobe; Tumor Site: lung.) ***Example 2:*** *Skin, left forearm.* (Tumor Site: Skin; Laterality & Sub-site: left forearm.)

***Primary Site:**

For solid tumors, use the search icon or use the ICD-O-3 book (purple book) to search for the primary site code. Code the site in which the primary tumor originated, even if it extends into an adjacent "sub-site". Code the primary site, not the site of metastasis. If primary site is not stated, code to unknown primary site (C809).

For hematopoietic and lymphoid neoplasms, use the following guide:

- Leukemia – Use primary site code C421 (bone marrow)
- Multiple myeloma – Use primary site code C421
- Lymphoma/Hodgkin's – Use primary site code C779 (lymph nodes, NOS)

TEXT - Primary Site:

Enter the primary site and laterality of the tumor being reported. Make sure to include the word Skin since skin is the primary site and location on the skin is the subsite. Example: Skin, Rt Forearm

***Laterality:**

Use the drop down and select the laterality of the primary tumor. Review the list of paired organ sites in Section 1, pages 7-8 to determine which primary sites require tumor laterality coded. For tumors which are not listed as a paired organ, select "0" (organ is not a paired site).

***Histologic Type:**

For solid tumors, use the search icon or use the ICD-O-3.2 Spreadsheet to search for the histology code. The ICD-O3.2 histology lists have been updated however a published manual has been delayed due to the COVID-19 pandemic.
If a report only has a diagnosis of "cancer" or "malignancy," code to 8000, malignant neoplasm. If a diagnosis is reported as "carcinoma," code to 8010.

For hematopoietic and lymphoid neoplasms, use the following guide for histology coding:

- Acute myeloid leukemia (AML) – 9861
- Chronic myeloid leukemia (CML) – 9863
- Acute lymphoblastic leukemia (ALL) – 9811
- Chronic lymphocytic leukemia (CLL) – 9823
- Non Hodgkin Lymphoma – 9591
- Hodgkin's Disease (lymphoma) – 9650
- Multiple myeloma (Plasma Cell Myeloma) – 9732
- Myelodysplastic syndrome – 9989

***Behavior Code:**

Use the drop down and select the behavior of the primary tumor. Tumor behavior is used by pathologists to describe whether the tumor is benign (0), borderline (1), in situ (2) or malignant (3). Benign and borderline behavior codes are used for intracranial and central nervous system

primary sites only. In the absence of pathologic examination, code behavior as invasive (3). In situ behavior (2) can only be identified by pathologic examination.

***TEXT - Histology:**

Document the histology (morphology) of the primary tumor site, including grade and behavior. Do not leave blank. Histology – Text is the written description of the code entered in Histologic type.

***Diagnostic Confirmation:**

Use the drop down and select the appropriate method of diagnostic confirmation. (See Section 1, pages 8-9 for instructions for coding diagnostic confirmation).

***Grade Clinical:**

Defined as the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). Record the grade of the primary tumor from the biopsy specimen. ***This data item cannot be blank*.**

> **Note: Benign Brain, CNS and Other Intracranial gland:** For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies. This was confirmed by the Colle ge of American Pathology (CAP) Cancer Committee.

***Grade Pathological:**

Record the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical work-up or the surgical resection. If the patient has not yet had or there is no plan to have a surgical resection, use code 9. ***This data item cannot be blank.***

***Grade Post Therapy Clinical (yc):**

New beginning 01/01/2021. Record the grade of a solid primary tumor that has been microscopically sampled (biopsied) after neoadjuvant therapy or primary systemic/radiation therapy has been administered. Record the highest grade documented from the microscopically sampled (biopsied) specimen of the primary site following neoadjuvant therapy or primary systemic/radiation therapy. Only code this data item if the patient has had cancer related neoadjuvant treatment, meaning after diagnosis that was followed by a biopsy. The patient may or may not proceed to have the planned surgical resection to remove any remaining cancer based on the biopsy results. *This data item may be blank.*

***Grade Post Therapy Path (yp):**

Record the grade of a solid primary tumor that has been surgically resected following neoadjuvant therapy. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy. *This data item may be blank.*

***Regional Lymph Nodes Positive:**

Record the exact number of regional nodes examined by the pathologist and found to contain metastasis. If biopsy or aspiration of regional node is positive, code “95”. If no regional lymph

nodes were examined by pathologist, code “98”. Use the search icon and select appropriate positive regional nodes value if no exact number is stated.

Example: *Two regional nodes are positive as reported by the pathologist. Record Regional LN*
Positive as 02.

***Regional Lymph Nodes Examined:**

Record the total number of regional lymph nodes that were removed and examined by the pathologist. If only biopsy or aspiration of regional node is performed, code “95”. If no regional lymph nodes were examined by pathologist, code “00”. Use the search icon and select appropriate examined regional nodes if no exact number is stated.

Example: *Pathologists states that 15 regional lymph nodes were removed during resection of a colon cancer. Record Regional LN Examined as 15.*

Lymphovascular Invasion

Lymphovascular invasion (LVI) indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. LVI includes lymphatic invasion, vascular invasion, and lymphovascular invasion.

Text – Diagnosis

***Physical Exam Text:**

Document the patient’s history of the tumor and the clinical description of the tumor from the history and physical. Document any risk factors. Include gender, age, race and ethnicity. If *Physical Exam* is unknown or not applicable, record “NONE”. Do not leave blank. You should always be able to record at least the patient’s age, race (if collected) and sex.

How to document in text field: *54 year old white male with a dark brown area on the left forearm approximately 1 cm. History of smoking, 2 packs a day for 20 years. No personal history of cancer.*

***X-ray/Scan--Text:**

Document all imaging examinations which provide information on tumor characteristics. Include the date imaging examinations were done, name of the imaging examination and a brief description of the findings. Include information from the Impression section and any other pertinent information such as tumor size from the findings section of the report If *X-ray/Scan* is unknown or not applicable, record ‘NONE’ in the text box. Do not leave blank.

Note: Do not record Bi-Rads for mammograms. This cannot be used to determine reportable status.

How to document in text field: *11/21/12 CT Chest: 2.5 cm lesion within the RML of lung, with hilar and mediastinal adenopathy. Largest lymph node, right hilum 2.2 cm.*

***Scopes--Text:**

Document information from endoscopic examinations that provide information for staging and treatment. Examples of endoscopic examinations are colonoscopy, cystoscopy, nasopharyngoscopy, nasolaryngoscopy and mediastinoscopy. Include the date and name of endoscopy along with the abnormal findings and tumor size. Colon and esophagus should also include the scope starting and ending centimeters If the physician documents this in the report. If Scopes is unknown or not applicable, record 'NONE' in the text box. Do not leave blank.

How to document in text field: *4/2/18 Colonoscopy: Large fungating mass in the sigmoid colon beginning at 20 cm from the anal verge and extending to 24 cm, 4 cm in length, biopsied.*

***Lab Tests Text:**

Document information from pertinent laboratory examinations (other than cytology or histopathology). Examples of pertinent laboratory results include CEA for colon cancer, ER/PR/HER2 for breast cancer, and LDH for malignant melanoma. Document Date of lab, Name of lab, Result of lab, Normal range of lab from the lab report. If Lab Tests are unknown or not applicable, record 'NONE' in the text box. Do not leave blank.

How to document in text field: *3/16/18 CEA 5.4 (0-4 normal).*

***Operative report Text:**

Text area for manual documentation of all biopsy and surgical procedures that provide information for staging. Document dates and names of procedures along with abnormal findings. If *Dx Procedures* is unknown or not applicable, record 'NONE' in the text field. Do not leave blank.

How to document in text field: *8/6/18 Punch biopsy of dark skin lesion on left forearm.*

***Pathology--Text:**

Document information from cytology and pathology reports. Include date of procedure, name of procedure or site of biopsy, tumor type, grade, involvement of resected margins, number of nodes removed and any additional comments or addendums which confirm or change the initial diagnosis. If *Pathology* is unknown or not applicable, record 'NONE' in the text field. Do not leave blank.

How to document in text field: *9/5/18 Wide excision Skin Lt forearm: biopsy site changes. No residual melanoma identified. All surgical resection margins are negative. No lymph nodes were examined.*

Place of Diagnosis--Text:

Document the name of the facility, physician office, city and state where the diagnosis was made, if available. This field can be blank.

How to document in text field: *Small Town Regional Hospital, Small Town, OK*

Stage of Disease

***Tumor Size Summary:**

Record the largest dimension or diameter of the primary tumor in millimeters in this 3-digit field. 1 centimeter (cm) is equal to 10 millimeters (mm). To convert centimeters to millimeters, multiply by 10. Use the search icon and select an appropriate tumor size if an exact measurement is not stated.

Example: *Tumor is described as 3.5 cm. 3.5 cm x 10 = 35 mm. Record Tumor Size as 035*.

***Summary Stage 2018**

Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time. Use the Summary Stage manual to help you determine the stage.

***Staging Text:**

Please include description of:

1) Tumor size and extension, and how they were assessed
2) Lymph node involvement, and how involvement was assessed
3) Assessment for metastasis
4) Any other information pertaining to staging.

e.g. SS2018- 9 Unknown- biopsy only
e.g. SS2018- 1 localized - confined to the primary site after surgical resection and lymph node biopsy.

Site Specific Data Items

***Site Specific Data Items**

Site specific data items apply to specific primary sites, histologies and years of diagnosis. To display the relevant SSDIs for the case, you must first enter the Date of first contact, Sex, Date of diagnosis, Primary site, Histology and Behavior then click Save. Use the magnifying glass next to the data item for code choices and instructions for coding.

Note: Some site and histology combinations also require schema discriminators. These will be listed in the SSDI section. You will also be notified with a pop-up message letting you know a schema discriminator is required.

OCCR Required SSDIs

Site	NAACCR Item #	Item Name	Primary Site(s)	Histologies
Brain	3816	Brain Molecular Markers	C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9702-9715, 9751-9759; *Behavior 3*
			C700, C710-C719	8000-9993; *Behavior 0,1*
Melanoma Skin	3817	Breslow Tumor Thickness	C000-C002, C006, C440-C449, C500, C510-C512, C518-C519, C600-C602, C608-C609, C632	8720-8790
	3932	LDH Lab Value		
Breast	3827	Estrogen Receptor Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
	3915	Progesterone Receptor Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
	3855	HER2 Overall Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
Liver	3835	Fibrosis Score	C220	8000-8700, 8720-8790
Prostate	3838	Gleason Patterns Clinical	C619	8000-8700, 8720-8790
	3840	Gleason Score Clinical		
	3839	Gleason Patterns Pathological		
	3841	Gleason Score Pathological		
	3842	Gleason Tertiary Pattern		
	3920	PSA Lab Value		
Colon & Rectum	3890	Microsatellite Instability (MSI)	C180, C182-C189, C199, C209	8000-8149, 8154, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790
Cervix	3956	p16	C530-C531, C538-C539	8000-8700, 8720-8790, 8980, 9110 Year of Diagnosis: 2021-9998, 9999
Esophagus & EG J (Squamous)	3829	Esophagus and EGJ Tumor Epicenter New for OCCR 2022+	C150-C155, C158-159 C160	8050-8054, 8020, 8070, 8074, 8077, 8083, 8560

Schema Discriminator 1 & 2:

Captures additional information needed to generate AJCC ID and Schema ID for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

Only certain primary sites require the schema discriminators to be coded. If the primary site requires it, you will see it in the display.

Brain Molecular Markers:

Required for certain Brain. Multiple brain molecular markers have become standard pathology components necessary for diagnosis. This data item captures clinically important brain cancer subtypes identified by molecular markers that are not distinguishable by ICD-O-3 codes. Use the magnifying glass for applicable codes and instructions.

Breslow Tumor Thickness

Required for Melanoma. Breslow Tumor Thickness, the measurement of the thickness of a melanoma as defined by Dr. Alexander Breslow, is a prognostic factor for Melanoma of the Skin. This is not the tumor size. Use the magnifying glass for applicable codes and instructions.

LDH Lab Value:

Required for Melanoma. LDH (Lactate Dehydrogenase) Lab Value, measured in serum, is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin. Use the magnifying glass for applicable codes and instructions.

Esophagus and EGJ Tumor Epicenter:

Required for Esophagus squamous tumors. Esophagus and Esophagogastric Junction (EGJ), Squamous Cell (including adenosquamous), Tumor Location refers to the position of the epicenter of the tumor in the esophagus. Use the magnifying glass for applicable codes and instructions.

Estrogen Receptor Summary

Required for Breast. ER (Estrogen Receptor) Summary is a summary of results of the estrogen receptor (ER) assay. This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

Progesterone Receptor Summary

Required for Breast. PR (Progesterone Receptor) Summary is a summary of results from the progesterone receptor (PR) assay. This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

HER2 Overall Summary

Required for Breast. HER2 Overall Summary is a summary of results from HER2 testing. This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

Fibrosis Score

Required for Liver. Fibrosis Score, the degree of fibrosis of the liver based on pathological examination, is a prognostic factor for liver cancer. Use the magnifying glass for applicable codes and instructions.

Gleason Patterns Clinical

Required for Prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from needle core biopsy or TURP. Use the magnifying glass for applicable codes and instructions.

Gleason Patterns Pathological

Required for Prostate. Prostate cancers are graded using Gleason score or pattern. Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy.

Gleason Score Clinical

Required for Prostate. This data item records the Gleason score based on adding the values for primary and secondary patterns in Needle Core Biopsy or TURP. Use the magnifying glass for applicable codes and instructions.

Gleason Score Pathological

Required for Prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy. Use the magnifying glass for applicable codes and instructions.

Gleason Tertiary Pattern

Required for Prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the tertiary pattern value from prostatectomy or autopsy. Use the magnifying glass for applicable codes and instructions.

PSA (Prostatic Specific Antigen)

Required for Prostate. PSA (Prostatic Specific Antigen) is a protein produced by cells of the prostate gland and is elevated in patients with prostate cancer. This data item pertains to PSA lab value. Use the magnifying glass for applicable codes and instructions.

Microsatellite Instability (MSI)

Required for Colon and Rectum. Microsatellite Instability (MSI) is a form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences (known as DNA microsatellite sequences). High MSI, found in about 15% of colorectal carcinomas, is an adverse prognostic factor and predicts poor response to 5-FU chemotherapy. High MSI is a hallmark of hereditary nonpolyposis colorectal carcinoma, also known as Lynch syndrome. Use the magnifying glass for applicable codes and instructions.

p16

Required for Cervix. The p16 biomarker is over-expressed (produced) in response to HPV. It is therefore a surrogate marker for HPV disease. Use the magnifying glass for applicable codes and instructions.

First Course of Treatment

***Diagnostic Procedure:**

Use the drop down and select the appropriate diagnostic procedure, usually biopsy of primary site or biopsy of other site. If no diagnostic procedure was performed, leave blank or code 00-No surgical diagnostic or staging procedure performed.

***Date Diagnostic Procedure:**

Record the date of the biopsy of primary site or the biopsy of other site. If no diagnostic procedure was performed, leave blank. (Refer to Note 1 Page 12 for date format).

Date DX Procedure Flag:

Flag explains why no appropriate value is in the field *Date Diagnostic Procedure*. Data item will be left blank if the *Date Diagnostic Procedure* is known. Use the drop down and select the appropriate value if date is not known.

***TEXT - Surgery:**

Document information from the operative report. Include date of surgery, name of procedure performed, and any pertinent surgical findings noted. If *Surgery* is unknown or not applicable, record 'NONE' in the text field. Do not leave blank.

> ***How to document in text field:*** *2/12/18 Wide local excision of malignant melanoma, Rt chest, with 2cm margins.*

***Surgery Primary Site:**

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment. If no surgery to primary site was performed, record '00'.

> *Note:* Transurethral resection of a bladder tumor (TURBT) and Excisional biopsy of any site* is surgery code 27 and should not be coded as 02 in diagnostic procedure.
>
> > **Exception:* Excisional biopsy of a lymph node performed to diagnose lymphoma is coded as 02 in diagnostic procedures.

***Date--Surgery:**

Record the date of the surgical procedure to the primary site. Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. If no surgery, leave, BLANK. (Refer to Note 1 Page 12 for date format).

Date – Surgery Flag:

Flag explains why no appropriate value is in the field *Date - Surgery*. Data item will be left blank if the date is known. Use the drop down and select the appropriate value if the date is not known.

TEXT - Radiation (Beam)
Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation. Minimum required text: dates and treatment modality. If no radiation, document NONE.

TEXT - Radiation Other
Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. Minimum required text: dates and treatment modality. If no radiation, document NONE.

Phase I Radiation Treatment Modality
Identifies the radiation modality administered during the first phase of radiation treatment delivered as part of the first course of treatment.

Date Radiation Started
Records the date on which radiation therapy began at any facility that is part of the first course of treatment. Use Date format YYYYMMDD.

Date Radiation Ended
The date on which the patient completes or receives the last radiation treatment at any facility. Use date format YYYYMMDD.

Date Radiation Ended Flag
This flag explains why no appropriate value is in the field, RX Date Rad Ended.

TEXT - Chemotherapy
Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor. Document dates and names of drugs administered. If no chemotherapy, document NONE

Chemotherapy
Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Use SEER*Rx to determine drug categories and reportability. https://seer.cancer.gov/seertools/seerrx/

Date Chemotherapy
Date of initiation of chemotherapy that is part of the first course of treatment. Use date format YYYYMMDD.

Date Chemotherapy Flag
This flag explains why no appropriate value is in the field, Date Chemotherapy.

TEXT - Hormone Therapy

Text area for information about hormonal treatment. Include dates and names of drugs administered. If no hormone therapy, enter None.

Hormone Therapy

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure. Use SEER*Rx to determine drug categories and reportability.
https://seer.cancer.gov/seertools/seerrx/

Date Hormone Therapy

Date of initiation for hormone therapy that is part of the first course of treatment. Use date format YYYYMMDD. If no hormone therapy, leave BLANK.

Date Hormone Therapy Flag

This flag explains why no appropriate value is in the field, Date Hormone Therapy.

TEXT - Immunotherapy

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy. Enter dates and names of drugs administered. If no immunotherapy, enter None.

Immunotherapy

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells. Use SEER*Rx to determine drug categories and reportability.
https://seer.cancer.gov/seertools/seerrx/

Date Immunotherapy

Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. use date format YYYYMMDD. If no Immunotherapy, leave BLANK.

Date Immunotherapy Flag

This flag explains why no appropriate value is in the field, Date Immunotherapy.

TEXT - Other Treatment

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical

trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field. If no other treatment administered, enter None.

Other Treatment

Identifies other treatment (Tx) given at all facilities that cannot be defined as surgery, radiation, or systemic therapy. Tx for reportable hematopoietic diseases can be supportive care, observation, or any TX that does not meet the usual definition in which Tx modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin. Use SEER*Rx to determine drug categories and reportability. https://seer.cancer.gov/seertools/seerrx/

Date Other Treatment

Date of initiation for other treatment that is part of the first course of treatment at any facility. Use date format YYYYMMDD. If no other treatment, leave BLANK.

Date Other Treatment Flag

This flag explains why no appropriate value is in the field, Date Other Treatment Started.

***Regional Lymph Node Surgery:**

Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

***Surgery of Other Regional/Distant Site:**

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Reason No Surgery:

Records the reason that no surgery was performed on the primary site.

Reason No Radiation:

Code the reason the patient did not receive radiation treatment as part of first course of therapy.

Radiation/Surgery Sequence:

Codes for the sequencing of radiation and surgery given as part of the first course of treatment. Surgery includes Surgery Prim Site, Regional LN Surgery, Surgery Other Reg/Dist site.

Systemic/Surgery Sequence:

Records the sequencing of systemic therapy (Chemo, Hormone, Immunotherapy, and Transplant/Endocrine) and surgical procedures given as part of the first course of treatment.

Surgical procedures are Surgery Primary Site, Scope of LN Surgery and Surgery Other Reg/Distant Site.

Treatment Status:
This data item is a summary of the status for all treatment modalities. It is used to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting).

First Treatment Date:
Date of initiation of the first therapy for the cancer being reported. The date of first treatment includes the date a decision was made not to treat the patient.

First Treatment Date Flag:
This flag explains why no appropriate value is in the field, first treatment date.

Treatment Date Most Definitive Surgery:
Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. When the patient has more than one surgical procedure, use the date of the most definitive surgery. e.g. Patient has surgery of the primary site, and the margins are positive. The patient has a re-excision and margins are now negative. The re-excision date is the most definitive.

Treatment Date Most Definitive Surgery Flag:
This flag explains why no appropriate value is in the field, Treatment Date Most Definitive Surgery.

Patient Outcomes

***DateLastContact/Death:**
Record the date of last contact with the patient or record the date of death. (Refer to Note 1 Page 12 for date format).

DateLastContact/DeathFlag:
Code explains why no appropriate value is in the field *DateLastContact/Death*. Data item will be left blank if the date is known. Use the drop down and select "12" if the date is not known.

***Vital Status:**
Use the drop down and select the vital status of the patient. If the patient has multiple tumors, vital status should be the same for all tumors.

Cause of Death:

Patient Alive = 0000; Patient Expired = 7777

ICD Revision Number:

Patient Alive = 0; Patient Expired = 1

Place of Death State:

Patient Alive = blank; Patient Expired = Abbreviation for state of expiration; See SEER Coding Manual Appendix B for Country and State codes: https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_B.pdf

Place of Death Country:

Patient Alive = blank; Patient Expired = Abbreviation for country of death. See SEER Coding Manual Appendix B for Country and State codes: https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_B.pdf

Treatment Referral Information

Physician Primary Surgery:

Use the table to code the physician. License numbers from the Oklahoma State Medical Board are used to populate this field. If a physician is not listed in the look-up table, leave this field blank and document the physician name in the Physician/Referral/Remarks text box.

Physician/Referral/Remarks:

Enter the names of any physicians or facilities to which the patient was referred to or from. If the primary surgery physician is not in the table, you may enter the name here. Additionally other remarks may be placed in this box as needed.

Date Case Completed:

Enter the date the case was completed in YYYYMMDD format. Completed means all edit errors and missing critical fields have been resolved.

EDIT Over-Ride Flags

Note: not all abstract displays will show all of the over-ride options.

Over-ride Age/Site/Morphology:

Some computer edits indicate possible errors that require manual review for resolution. If you receive this edit error, review the age, site and morphology codes for accuracy. If the codes are correct, then code the over-ride as 1 for reviewed.

Over-ride Seq No/Dx Confirmation:
Some computer edits indicate possible errors that require manual review for resolution. If you receive this edit error, review the diagnostic confirmation and sequence number for accuracy. If the codes are correct, then code the over-ride as 1 for reviewed.

Over-ride Site/Lat/Seq No:
Some computer edits indicate possible errors that require manual review for resolution. If you receive this edit error, review the primary site laterality and sequence number for accuracy. If the codes are correct, then code the over-ride as 1 for reviewed.

Over-ride Surg/Dx Conf:
Some computer edits indicate possible errors that require manual review for resolution. If you receive this edit error, review the surgery and diagnostic confirmation codes for accuracy. If the codes are correct, then code the over-ride as 1 for reviewed.

Over-ride Site/Type:
Some computer edits indicate possible errors that require manual review for resolution. If you receive this edit error, review the primary site and the histology code for accuracy. If the codes are correct, then code the over-ride as 1 for reviewed.

Over-ride Histology:
Some computer edits indicate possible errors that require manual review for resolution. If you receive this edit error, review the histology code for accuracy. If the code is correct, then code the over-ride as 1 for reviewed.

Save Abstract and Run Data Edits

Click the “Save” button in the lower left corner of the screen. The abstract will be saved, and data edits will run. Edit errors and missing critical fields will be displayed on the right side of the screen. All edit errors and critical fields must be resolved before the abstract can be considered complete and ready to be released.

Section 3

Web Plus Training Manual for Facility Abstractors

OKLAHOMA State Department of Health

Web Plus

Application for Secure Cancer Reporting Over the WWW

Facility Users
(Abstractors and File Uploaders)

(Based on Web Plus Version 3.10)

February 2022

Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division of Cancer Prevention and Control

National Program of Cancer Registries

Registry Plus™ Software for Cancer Registries

National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control

Introduction

Web Plus Features

Web Plus is used by facilities to report cancer cases to Central Cancer Registries. A variety of facility types (hospitals, physicians' offices, laboratories, radiation facilities and so on) use Web Plus for cancer case reporting. Smaller hospitals and other low-volume reporters use Web Plus for online entry of cancer case abstracts which is addressed in this manual. Larger facilities, particularly hospitals, use Web Plus to report via upload of NAACCR-formatted files (abstracts are created in a separate system, bundled, and uploaded in Web Plus). All facilities can use Web Plus to upload and download supporting documents in any file format.

All records are saved in a database at the hosting central cancer registry and cases entered by one facility or office are not visible to other facilities. Data entered are validated by the CDC EDITS Engine running on a web server. Users, display types, and edit configurations are managed at the hosting central registry. Web Plus is hosted on a secure web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Socket Layer (SSL) technology.

Web Plus Users

Users	Description
Facility Abstractor	Works in a facility or doctor's office and handles patients' medical records and paperwork. When a patient is diagnosed with cancer, the Facility Abstractor reports the case to the state's central cancer registry. The Facility Abstractor also completes and submits any follow-back abstracts that the central registry has posted for their facility.
File Uploader	Uploads either files of abstracts in the appropriate NAACCR format that were not abstracted using Web Plus or non-NAACCR files in any format, views EDITS error report and cleans, or works with abstractors to clean, errors on rejected abstracts prior to resubmitting, downloads files posted by the central registry, and views reports.

Online Abstracting

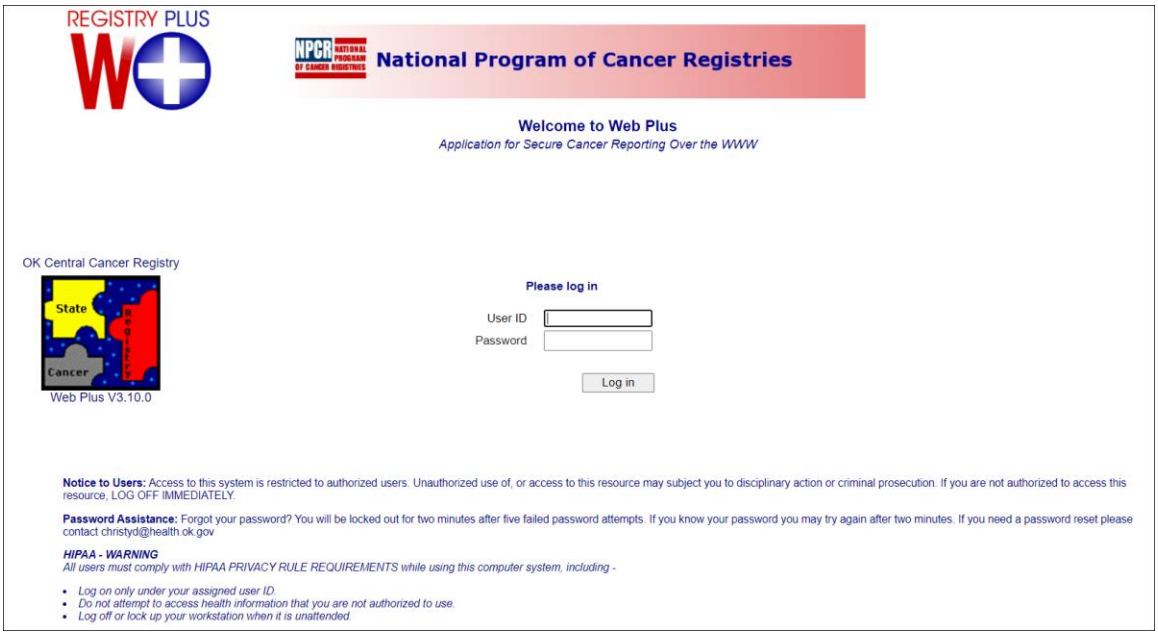
Log In

1. Open your Internet browser and type the following link in the address bar:

   https://occrweb.health.ok.gov/

2. Press **Enter**.

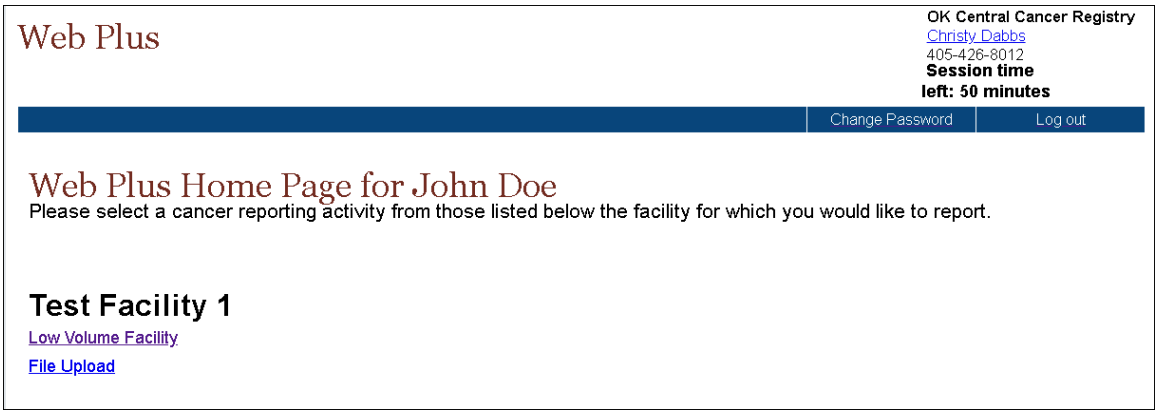
   Result: The Oklahoma Central Cancer Registry Web Plus Log in page opens.



Type in the User ID and password provided to you by your central registry into the User ID and Password fields.

3. Click **Log in**.

Result: Your Web Plus homepage opens, with a list of links to the facilities and roles that have been assigned to you. You can also change your password from this screen.



4. Click the link for the assigned Display: **Dermatology, Low Vol Facility Providing TX or Low Vol Facility-No Treatment.**

Result: The Facility Abstractor menu items are displayed in the blue bar.

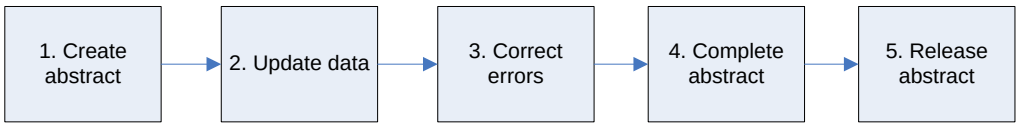
From this page you can access the main sections of Web Plus. Click on a menu option to open the page for the option.

This table describes the menu options on the home page:

Menu option	Description
Home	Opens the user's home page, which displays a list of links for the facilities and roles that have been assigned to you; to work on abstracts of a particular source, click on the link for the type of abstract
New Abstract	Opens the data entry page for a new abstract
Find/Open Abstract	Opens the page to search for existing abstracts
Release Abstracts	Opens the page that lists all abstracts that are completed and ready for release
Reports	Opens the page that lists the reports available for viewing
Change Password	Opens the change password page
Help	About - Opens a page with the Web Plus, NAACCR, and Collaborative Staging Algorithm Version information
Log out	Logs the user out of Web Plus; opens Web Plus Log in page

Abstracting

The process of creating an abstract, entering data and ultimately releasing it to the central registry will all be done in Web Plus. After you create an abstract, you can save it at any time and return to your work at a later time. You can release the abstract to your central registry only after you have completed it and eliminated any errors it may contain.



The process of generating an abstract includes the following steps:

1. Create the abstract with the patient's name and social security number and save. You can add more information to the abstract and complete it whenever you want.
2. Enter codes using the codes supplied by the Web Plus application in the drop down lists and text in the data entry fields. Save the abstract to retain the information you have entered.

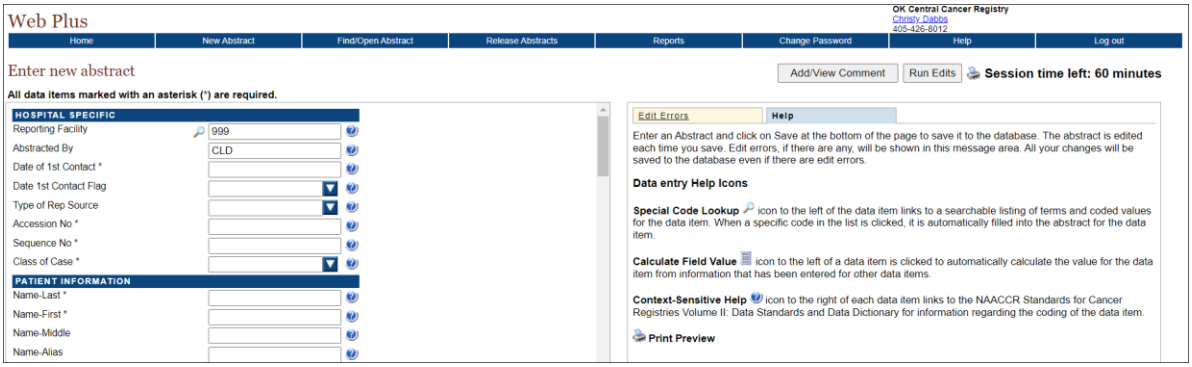
3. Correct errors. Each time you open or save the abstract, Web Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by the OCCR Web Plus Administrator.
4. After you have entered all your data , corrected all errors and entered all missing critical fields save the abstract and the system will designate your new abstract as complete.
5. Release the completed abstract to the central registry. You can release abstracts individually at the time of completion or several at a time.

Create a New Abstract

Enter your case information on the new abstract page. To open the new abstract page and view its content, follow these steps:

1. In the Web Plus menu, click **New Abstract**.

Result: The Data Entry page opens.



There are two main sections; the box on the left contains the fields where case information is entered, and the box on the right has two tabs: Help and Edit Errors. In addition, there are two buttons to the right (**Add/View Comment** and **Run Edits**), a printer icon, and information on the time left in the session (inactivity causes the session time left to decrease).

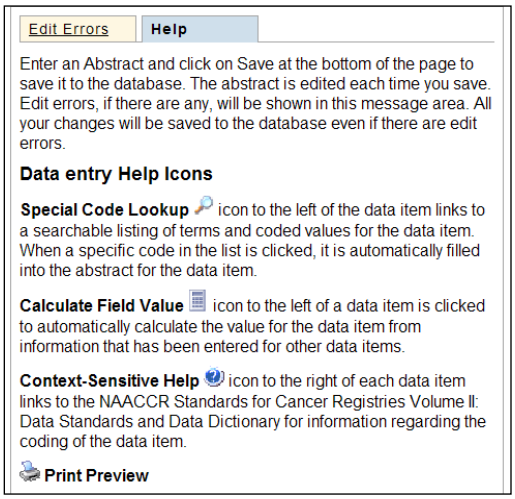
2. In the entry box on the left, scroll down the list to view all of the fields in the data entry grid, including the text fields.

   The fields you see depend on your facility or center and the set up chosen by your central registry Web Plus Administrator. The headings, such as Hospital Specific and Demographic, can vary. These are only headings; they do not signify a group of required fields. Your Web Plus Administrator uses them to organize the fields for clearer viewing and to help with data entry.

In the right box, click each of the tabs to see the content for **Edit Errors** and **Help**

Tab	Description
Edit Errors	This area lists any errors that exist after you have opened or saved the abstract. This editing feature helps you complete the abstract until it meets the standards acceptable to the central registry. You will learn more about the edit errors tab on page 43.
Help	This area describes the saving and editing of an abstract and provides a description of the data entry help icons available to the abstractor.

3. The Help tab describes saving and editing an abstract and provides a description of the data entry Help icons.



These are the Web Plus icons:

Icon	Description	Click the icon to . . .
	Special Lookups	open a listing of codes and terms to choose from. Find the term that best applies and click on the code to the left of the term. When a specific code is clicked, it is automatically filled into the abstract for the data item.
	Calculate Field Value	calculate a value for a field from values in other fields.
	Context-sensitive Help	open Help page with the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item.

Icon	Description	Click the icon to . . .
	Print Preview	open page that shows all of the fields and the content you have entered in your abstract; this page allows you to print a copy of your abstract.

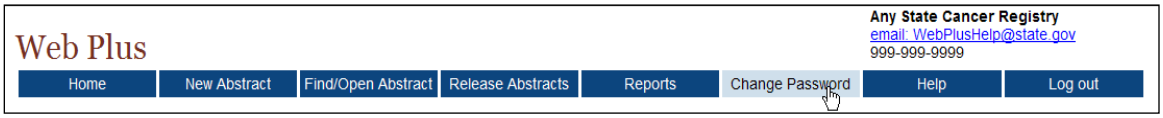
4. **Saving: It is very important to Save regularly while abstracting**. Web Plus does not automatically save an abstract. When you click **Save**, the Edit Errors tab will open on the right and a list of edit errors will appear in the window. You don't have to immediately fix the errors, as entering more information will clear many errors.

   Also, when clicking save, you will be taken to the top of the abstract (even if that is not where you were last entering information).

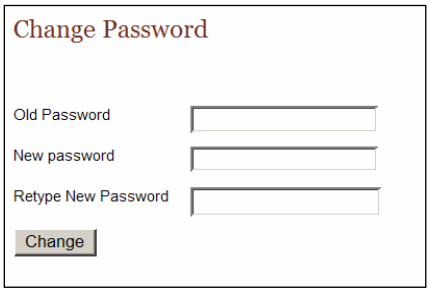
Changing Your Password

To change your password, complete these steps:

1. On the Home page menu, click **Change Password**.



   Result: The Change Password page opens.



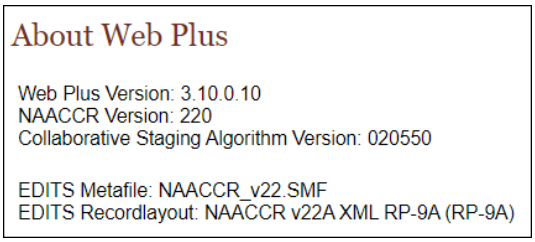
2. Type your **current** password in the **Old Password** field.
3. Type your **new** password in both of the **New Password** fields.
4. Click **Change**.

Web Plus Version Information

To view Web Plus, NAACCR, and Collaborative Staging Algorithm Version information, complete these steps:

1. On the Web Plus menu, select **Help.**
2. Select **About.**

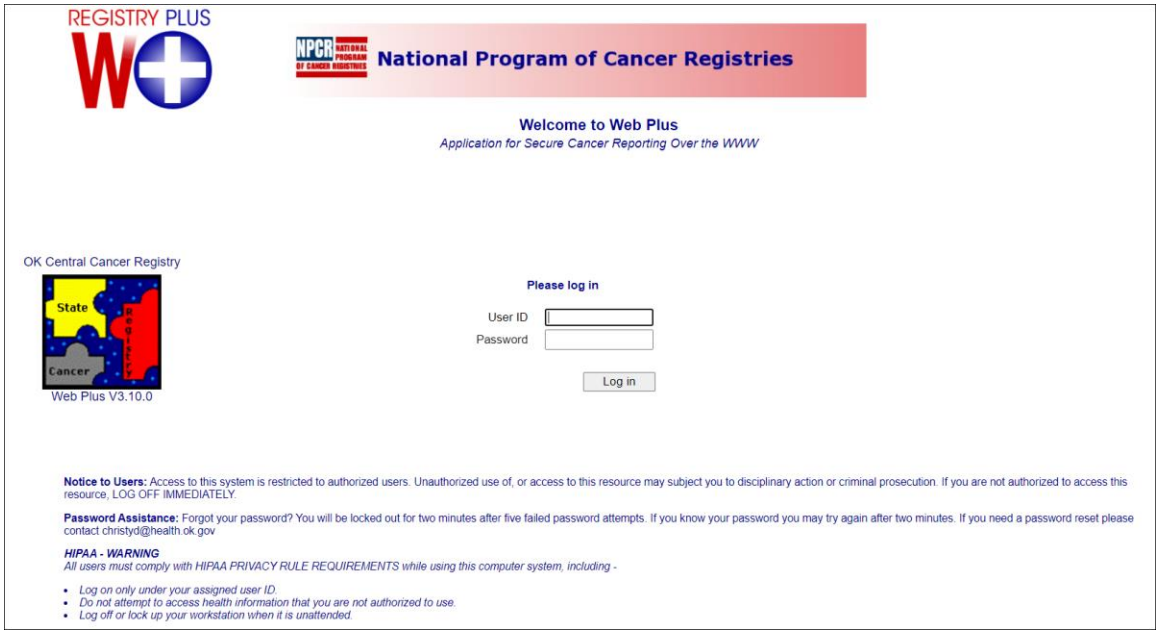
Result: A page opens with information about the version of the Web Plus application, and the NAACCR and Collaborative Staging Algorithm versions included in the Web Plus application.



Logging Out

To log out of the Web Plus application, click **Log out** on the Home page menu.

Result: The Web Plus Log In page opens



Adding Data to a Saved Abstract

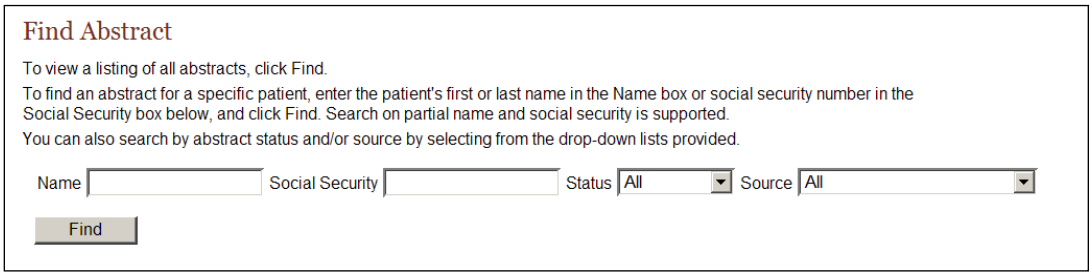
Opening and Updating an Abstract

In this section, you learn to find an existing abstract and open it, use a calculator field, and use pop-up window information.

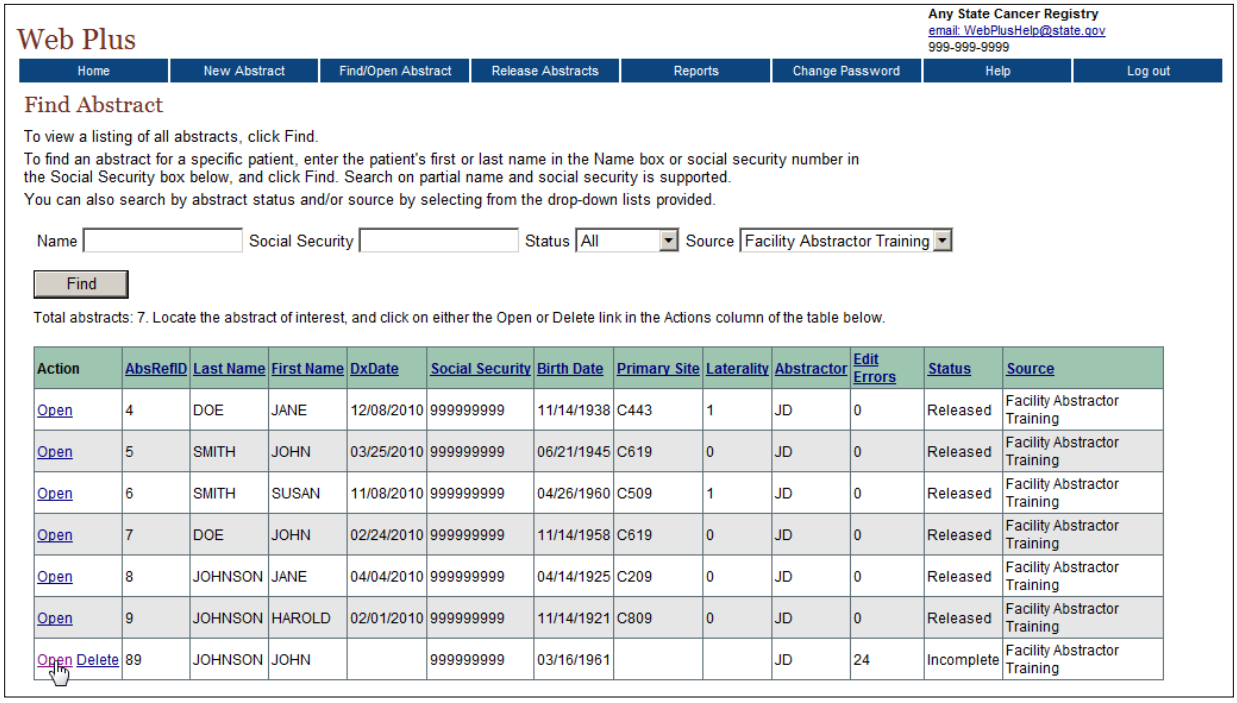
To update an abstract, follow these steps:

1. Log in, if you are not already, as described in "Log In," page 34.
2. On the Web Plus menu, click **Find/Open Abstract**.

Result: The **Find Abstract** page opens.



The Find Abstract page is searchable by patient name, social security number, abstract status, and/or abstract source.



Action	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status	Source
Open	4	DOE	JANE	12/08/2010	999999999	11/14/1938	C443	1	JD	0	Released	Facility Abstractor Training
Open	5	SMITH	JOHN	03/25/2010	999999999	06/21/1945	C619	0	JD	0	Released	Facility Abstractor Training
Open	6	SMITH	SUSAN	11/08/2010	999999999	04/26/1960	C509	1	JD	0	Released	Facility Abstractor Training
Open	7	DOE	JOHN	02/24/2010	999999999	11/14/1958	C619	0	JD	0	Released	Facility Abstractor Training
Open	8	JOHNSON	JANE	04/04/2010	999999999	04/14/1925	C209	0	JD	0	Released	Facility Abstractor Training
Open	9	JOHNSON	HAROLD	02/01/2010	999999999	11/14/1921	C809	0	JD	0	Released	Facility Abstractor Training
Open Delete	89	JOHNSON	JOHN		999999999	03/16/1961			JD	24	Incomplete	Facility Abstractor Training

The list of abstracts has the following twelve columns:

Column Head	Description
Actions	You have the option to open or delete an abstract
AbsRefID	A system-generated number identifying the abstract
Last Name	Last name of patient
First Name	First name of patient
DxDate	Diagnosis date

Column Head	Description
Social Security	Patient's social security number
Birth Date	Patient's date of birth
Primary Site	The location of the major tumor
Laterality	Code for the side of a paired organ, or the side of the body on which the reportable tumor originated
Abstractor	Code for the person who created the abstract
Edit Errors	The number of errors found in the edit process after an abstract has been saved
Status	Web Plus has three types of statuses: • Incomplete (not all data have been entered) • Complete (all errors have been addressed) • Released (sent to the central registry)
Source	The type of Web Plus abstract; this is the name of the link that you clicked on your home page

***NOTE*: Released abstracts have been sent to the Central Registry and are no longer editable. Released abstracts are view only.**

3. The list of abstracts can be sorted in ascending order on any column
4. Click on **Open** in the Action column of an incomplete abstract, and the data entry page will open and display previously entered information. The heading of the abstract, above data entry fields, will be **Update Abstract**. In addition, upon opening the incomplete abstracts, edits will be automatically run and errors displayed on the right.

Print Preview

The Print Preview feature allows you to view all of the fields and the content you have entered in your abstract. You can also print a copy of the abstract from the Print Preview window.

1. Open an abstract.
2. Click **Print Preview**  .

   Result: A separate window opens that displays all of your abstract entry fields and content.
3. To print a copy of the abstract, use your browser's printer.

Correcting Edit Errors

Understanding Edit Sets

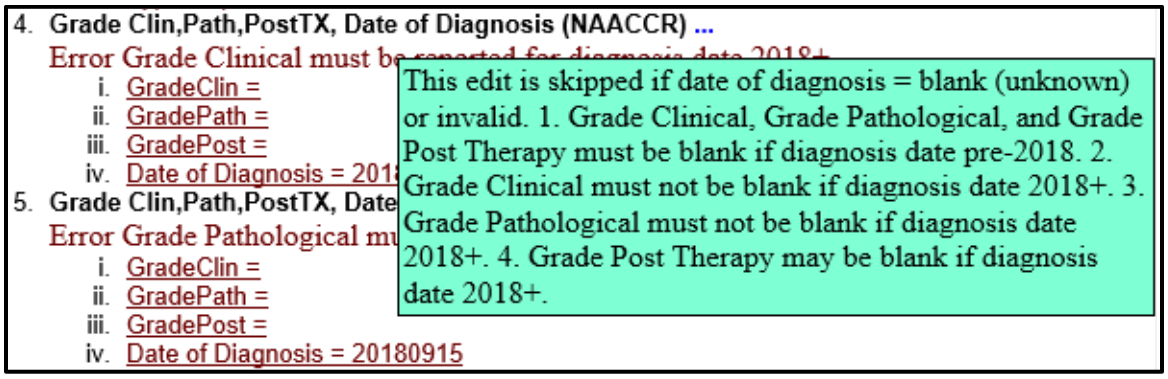
Each abstract is edited for data quality and completeness whenever you save or open it. The edits applied to the information depend on the edit set selected by the Plus Administrator at your central registry.

As an abstractor you must correct all identified errors and missing critical fields to complete your abstract prior to releasing it to the central registry.

Edit Errors Tab

The edit errors pane lists edits in the abstract. The edit set runs each time the abstract is saved or re-opened.

Each edit errors includes the name of the edit, the description of the error, and a link to the field (s) involved with the edit. Following the name of the edit is an ellipses (…); click on the ellipses to view detailed information about the edit. For example, clicking on the ellipses after edit error 4 below brings up the text in with the green background, which is further information about the edit.

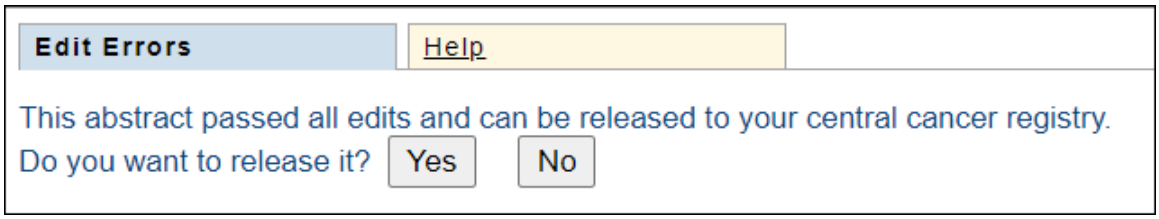


To correct abstract edit errors, you can click on the link to the field associated with the edit error, which is displayed just below the error description. This will take you to that field, which will now be located at the top of the abstract display on the left.

Completing and Releasing Abstracts

Completing the Abstract

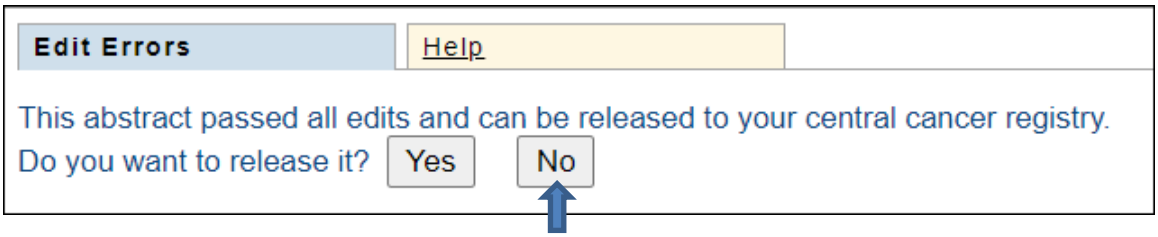
As mentioned, you must resolve all edit errors and fill in all critical (required) fields in order to complete an abstract. Once you have resolved all edit errors and completed all missing critical fields, upon the next save of the abstract, Web Plus informs you that the abstract is complete and ready for release to the central registry.



Note Critical (required) fields are labeled with an asterisk (*).

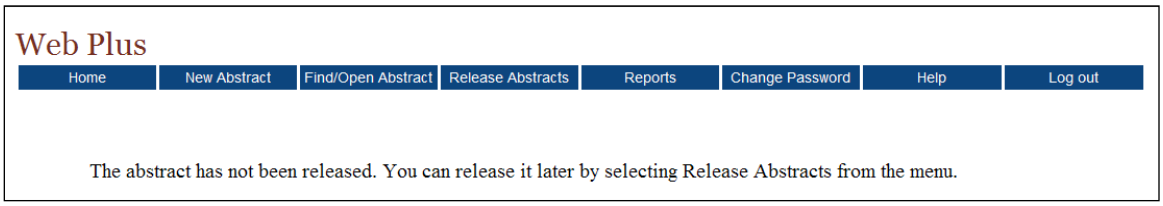
1. Click **Save** to save the last entries that you made.

   Result: Edits are run; the **Edit Result** shows **no errors**, and the application informs you that the abstract is **complete** and **ready for release** to the central registry.



2. **Do not** release the abstract now. Click **No** and go to the next section of this training manual, "Releasing the Abstract".

   Result: The abstract is saved and completed, but not released.

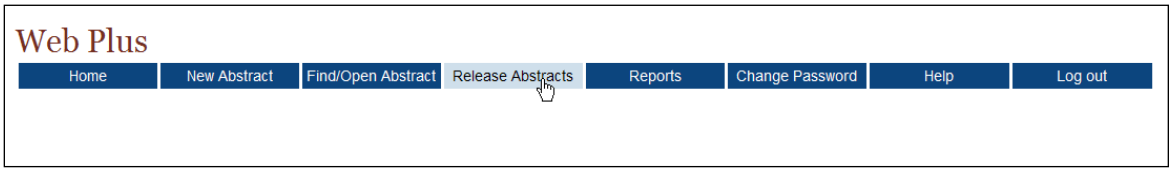


Releasing the Abstract

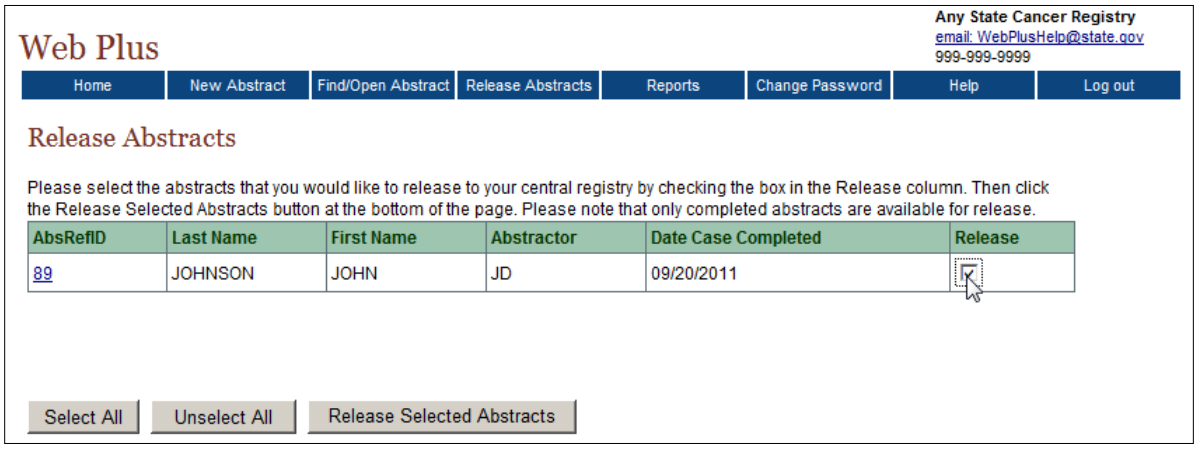
Once your abstract has no errors and no missing critical fields, it is complete, and you can release it to the central registry.

Follow these steps to release an abstract:

1. On the Web Plus menu, click **Release Abstracts**.



   Result: The system displays a list of completed abstracts.



2. Click the box in the Release column for the JOHN JOHNSON abstract.

Note To select all of the abstracts listed, click the **Select All** button.

3. Click **Release Selected Abstracts**.

   Result: The system releases the selected abstracts to your designated central registry and changes the status of the abstracts to Released. Use the Find/Open page to view the released abstracts. ***Note that you can view an abstract that has been released but cannot revise it.***

It is highly recommended to release abstracts in bundles to provide yourself an opportunity to review cases for incorrect codes or text prior to releasing the case.

Correcting Errors in Released Cases

After cases are released to the OCCR, they will be reviewed for completeness and accuracy. It's important to note that edits are not able to determine all errors within an abstract. Therefore a manual review by the OCCR is required. This is a critical step in the data review process to ensure that accurate data is submitted to the Centers for Disease Control and Prevention in the annual call for data.

1. The OCCR will review released cases for completeness and accuracy.

2. Comments for each case will be provided to the abstractor with a description of the data item, the correct coding or text format and the reason for the change.
3. The cases will be sent back for correction and will be listed as status *incomplete* in find/open abstracts.
4. The OCCR will email the abstractor with specific instructions for making corrections. A deadline for completion will be included.
5. The abstractor will make the corrections and release the case.
6. The OCCR will review the released case and verify all corrections have been made. If there is still a significant amount of errors, the case will be returned to the abstractor for correction.
7. If there are minimal errors, the OCCR will make the corrections, enter additional comments for corrections that were made and accept the case. The abstractor will be notified by email and can open each case, now status released, to view the additional comments.
8. If there are no errors, the case will be accepted. No additional email will be sent to the abstractor.

This publication was issued by the Oklahoma State Department of Health (OSDH), an equal opportunity employer and provider. A digital file has been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries in compliance with section 3-114 of Title 65 of the Oklahoma Statutes and is available for download at www.documents.ok.gov .| Issued June 2022